DEPARTMENT OF MENTAL HEALTH/MENTAL RETARDATION SERVICES

REQUEST FOR COMMUNICATION AND/OR DISCLOSURE RESTRICTIONS

Today's date_____

Name_____

Birthdate_____Medical record #_____

Phone Number (H)_____(W)_____

Address_____

I Request The Following Alternatives Or Limitations Relating To Communications Directed To Me By The Department:

_____

_____

_____

_____

_____ _____ _____

Print Name (Patient/Client) Signature Date

_____ _____ _____

Print Name (Witness) Signature Date

*Accepted *Denied Date:_____ _____

Signature

Reason:_____

I Request the following restrictions to the use or disclosure of my personally identifiable health information.

_____

_____

_____

_____

_____ _____ _____

Print Name (Patient/Client) Signature Date

_____ _____ _____

Print Name (Witness) Signature Date

*Accepted *Denied Date:_____ _____

Signature

Reason:_____

Filename: DEPARTMENT Request for communication Discl restrictions draft.doc
Directory: D:\Documents and Settings\bomayo\Desktop
Template: D:\Documents and Settings\bomayo\Application Data\Microsoft\Templates\Normal.dot
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Author: dschroeder
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Comments:
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